

Apr. '51
THE

CHILD

APRIL 1951



PARENTS CAN BE HELPED TO DO A BETTER JOB

Mothers learn from each other, with the help of a group worker

HELEN NORTHEN

A FATHER AND MOTHER are more likely to guide their children well if they continue to develop their own personalities than if they jog along in a rut. As we all know, mothers especially may become so tied down to diapers and dishes that they begin to feel they have lost their identity as persons.

This is the story of a small group of young women who felt that they were getting into a rut and who did something about it, with the help of a social group worker. They found their opportunities for developing their personalities through a club that they called the "Y-Actives."

Fourteen members made up the Y-Actives. They were all married women, whose parents were Polish or Irish, and all but three had children. Their ages ranged from 24 to 27. All were high-school graduates, but none had gone beyond. Two were working as stenographers; the rest were housewives.

A few, who formed the nucleus of the group, had been teen-age members of the YWCA during their high-school days, when they lived near one another in an industrial neighborhood. Later, when they married, they became a little better off financially, lived in residential neighborhoods, and felt freer of their parents' old-world culture patterns. But in their new homes they missed their former school friends and the closely knit church communities in the old neighborhoods.

A chance meeting between one of these young women and a former staff member of the YWCA led to a reunion of the old group. And they decided to form a club, taking in some other young married women. They hoped "to get time off

for fun" . . . "to do more things" . . . "to have some life of our own."

The YWCA agreed to assign a social worker to help with the club, and the Y-Actives came into being.

When the weekly meetings got under way the members chiefly concerned themselves with basketball, volleyball, playing cards, dancing, and eating. Then, after a while, they began making rag dolls for children who had no toys. For, as one member said, "When you're doing some good, you feel good."

Husbands enter the picture

They all talked about how wonderful it was to get away from home once a week, and they began to think that maybe their husbands needed some social life, too. And so they planned to invite the husbands once a month. This, of course, required arrangements for babysitting and for caring for older children. But they managed, and the husband-wife parties became regular features of the club program.

Helen Northen received her master's degree from the University of Pittsburgh's School of Social Work. She has been field instructor for that school and also program director at a branch of the Pittsburgh YWCA. While there she was the supervisor of the social group work programs, including the one described in this article.

She is now completing her work for the Ph.D. degree in the Graduate Department of Social Economy at Bryn Mawr College, where she is also research assistant. In September Miss Northen will become Associate Professor of Social Work at the University of Hawaii's School of Social Work.

Miss Northen gave this paper at the seventy-seventh annual meeting of the National Conference of Social Work, at Atlantic City, N. J.

After a few of these parties, delighted remarks could be heard during the regular meetings about how much less shy "Hubby" was in meeting new people or how much more relaxed he seemed in dancing and taking part in the other club activities. At one of the parties a couple showed some pictures of their children. Like a flash everyone, amid laughter, got out pictures of junior and sister, and the exhibits were passed around the group. Before the evening was over the club members had planned a family Christmas party for all ages.

The husband-wife parties continued throughout the year, winding up with a spirited dinner dance at a suburban hotel. Planning for this important event included saving money for it over many weeks, giving up other things for it, and putting a lot of time and effort into preparing for it. The willingness of members to plan and save and work revealed their pride in their club and their delight in carrying out social affairs that their husbands enjoyed with them.

Next the Y-Actives took up handicrafts, and they enjoyed the sense of accomplishment that goes with making things (pottery, for instance). Most of them made gifts for their husbands and children, or articles for their homes, such as rag rugs.

As time went on, the weekly meeting became more and more a time for talking over common problems, and these were many. In the relaxed atmosphere of a small friendly group, they discussed such matters as low-cost vacation trips, new labor-saving gadgets, baby sitters, and, more seriously, problems concerning the care and raising of children, prenatal care and care after confinement, difficulties with

their in-laws over such issues as Catholic-Protestant marriages, and doubled-up living arrangements.

The group worker also helped the young women plan more formal discussion meetings, with speakers or educational motion pictures on subjects related to family life.

For example, after the members had been discussing among themselves the difficulties they met day by day in bringing up their children, a staff member from the city's child-guidance clinic was invited to a meeting to talk about child development and about the work of the clinic—how it could help mothers and fathers to understand and to guide their children.

Discussions begin to pay dividends

At other meetings a nurse demonstrated first aid and home nursing. Later the group worker brought in books on sex education and showed movies on human growth and reproduction to help the members in their discussions. Informal talk at following meetings showed that members had been able to make good use of what they learned. One young mother, arranging to borrow

a book on sex education, said that she needed it because her 4-year-old daughter was at the question-asking stage. She had asked, for example, why her aunt—obviously pregnant—was “getting so fat.”

The mother was proud of herself for having been able to answer the little girl's question in a natural way, and she felt that she had been able to do that because she had learned so much in an earlier group discussion. Other mothers showed from time to time that they were beginning to understand themselves and their children's behavior better, and as a result were finding more satisfaction in being homemakers.

Gradually, the young women began to see that some of their own family concerns had a wider meaning; their concerns could be applied to the community as a larger family group, closely interrelated. They began to discuss such matters as how can better housing be achieved for all families, what are the respective roles of the family and the school in sex education, and how much the community needs more child-guidance and other chil-

dren's services. While they talked about this need for more services they learned about the central money-raising activities of the community chest. And they began to realize what it means to families and children that need specialized services, whenever the people of the city fail to give the full amount budgeted for these services. A direct result, for example, was that a child-guidance clinic might have too small a staff, and be obliged to turn away parents and children who needed service, or postpone giving them service because of a long waiting list.

Some difficulties call for individual help

Most of the young women gained the help they needed through the weekly contacts with one another and through discussion of the problems they were themselves wrestling with. From that point they could learn by applying their new knowledge or by following up their questions with reading or going to other sources of information that they had learned about at the club meetings.

A few members, however, had difficulties that they could not overcome solely through this group association. There was, for example, young Mrs. O. The group worker early guessed that this young woman needed individual help before she could benefit from the group experience. The worker could not help noticing how changeable Mrs. O became — she would be taking a cooperative part in the group's activities, and suddenly she would change to silence or aggressiveness. The worker watched and listened for reasons for this erratic behavior. After a while she heard Mrs. O remark that if she had a chance to decide again about getting married, she certainly would stay single. And she mentioned evidences of home difficulty, such as disagreements with her husband about disciplining the children; she brought a cousin instead of her husband to one of the parties; she talked about the trouble she was having with her in-laws because they objected to the marriage on religious grounds.

Family life is sometimes improved for both children and parents if the father and mother have opportunities to develop their own personalities instead of jogging along in a rut.



Mrs. O did gain some support from the other members' sympathy for her and their suggestions about dealing with her problems. Meanwhile the worker, who had developed a close relation with the troubled young woman, made her aware that she knew things were hard for her and offered her an opportunity to talk about finding help.

But Mrs. O's condition became increasingly worse. Finally she got so that she could not bear to have differences of opinion in the meetings go against her. One night, when things did not go her way, she resigned from the club. The worker made an opportunity that very night to talk with Mrs. O about why she was leaving, and Mrs. O asked her for an appointment for a personal talk. In this later interview the group worker

for help in understanding the difficulties of her own little girl. Mrs. H evidently could not, by herself, overcome her feelings of inadequacy about the way she was raising her daughter, and she welcomed the idea that she take her to the child-guidance center. Unfortunately the center had so long a waiting list that Mrs. H could not get help until some time later. Meanwhile, though, her difficulties were lessened somewhat by the aid and support she got from the other club members and from the group worker, and she felt more confident in handling her problems.

These steps toward more successful family life, which were obviously fulfilling the desires and needs of the club members, did not just happen. These young adults had been starving for social life; they

ried couples. She knew each member as an individual—what her special interests and needs were and how her family situation and community conditions were affecting her. She knew about a variety of program activities and how they could be used in helping individuals to develop their personalities and the group as a whole to achieve its objectives.

Step by step

Thus, she had begun by helping the members find release from the tension of home responsibilities through a weekly evening of active recreation. She knew that this need must be met before the group could focus on anything else. She understood, however, that the more fundamental need of most of the members was to succeed as wives and mothers. At appropriate times the worker encouraged the members to ask her cooperation in developing social activities that they could share with their husbands. She helped the members to come to the point of voicing their desire for help in resolving their problems of married life and of child rearing. She tried to lead the discussions in such a way that each member could take part, and to cultivate each one's sense of confidence in her ability to help the others.

The formal programs—the talks by specialists, the showing of movies—and the introduction of reading matter were successful, partly because the worker prepared the group in advance, and because the meetings were followed by discussions that answered questions and cleared up misunderstandings. Finally, when the club was ready, the worker helped the members to realize that some of their personal problems were related to wider community problems. Thus, the worker helped the group to deepen its own program, moving from recreation to the study of problems whose solution might lead to the strengthening of family life.

How the members of a group get along with one another is a factor in how they are able to profit from

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In the relaxed atmosphere of a small, friendly group, it is easy for young mothers to discuss everything from labor-saving gadgets to the serious problems of family life.

enabled Mrs. O to realize her need for help with her marital difficulties and her children's behavior problems. The worker helped her in making an appointment with the local family-service society to seek the assistance she needed.

Another member, Mrs. H, after she listened to other members tell of their experiences in raising their children and after she heard the talk by a staff member of the child-guidance center, showed her need

felt strongly that they needed a means of greater self-expression. And they poured thought, time, and energy into their efforts to advance. But they were not without guidance. At every step of the way, the social group worker was there to help them.

The worker had some knowledge and understanding of human behavior, particularly of child development, and had studied the problems of adjustment of young mar-

TO RESTORE THE CHILD WITH CLEFT PALATE

Professional and community teamwork will bring success

SAMUEL M. WISHIK, M.D.

WHEN A CHILD is born with cleft palate the family feels that it is a disaster, and often it becomes one. The parents feel that they must be to blame, and they are ashamed because they have produced an imperfect offspring. They feel stigmatized in the eyes of their neighbors and of society. The father and mother, as well as the other children in the family, may suffer emotional disturbances.

If these parents had known beforehand something about such defects as cleft palate and harelip (these are likely to occur in the same child) and had realized how much can be done to restore the child they would have been saved much unhappiness. People in general need to know more about the speech and facial defects that occur as a result of cleft palate and harelip. And they should also learn to see these defects in proper perspective with the person's other attributes. Too often do we jump to conclusions about a person's mental capacity because his speech is defective or his face is marred. More widespread information on such congenital defects and greater understanding of them would lead to better social acceptance of the individual.

Complete correction possible

The most hopeful aspect of cleft-palate correction is that with well-timed and adequate care 100-percent rehabilitation is possible in a large proportion of children. So far as we now know, cleft palate differs from certain other congeni-

tal and childhood handicaps in this possibility for complete or almost complete correction. We can attain for a child remarkable cosmetic results with surgery for harelip; effective closing of the cleft palate by surgery and use of mechanical devices; and ability to speak normally or almost normally through closing the child's palate and training him in speech. And consequently, wholesome social, psychological, and vocational adjustment to life becomes possible for him.

It is not necessary to be content with a partial result or a residual handicap. A large percentage of persons born with cleft palate should be able in adulthood to forget completely that they had had the condition when they were children.

Heredity is probably not a factor

Although we do not know the whole story of the factors that produce cleft palate and harelip (and similar defects such as clubfoot and birthmarks) in a child before birth, we do know that they result from *incomplete* development rather than

from *abnormal* development. We can theorize that the child born with harelip or cleft palate would have developed normally, with the lip and palate closed properly, if something had not arrested his growth before it was completed. We should not conclude that heredity is a factor merely because statistics indicate that these conditions often occur in several members of the same family, for it is possible that this could be due to environmental factors, such as faulty diet or disease. Studies made so far seem to give strong evidence that the physical condition of the mother during pregnancy may affect the completeness of closure of the child's palate or lip before birth.

In view of what we now believe about the causes of such defects as cleft palate, public-health programs for maternity care should give particular emphasis to better nutrition during pregnancy and to prevention of illness during the early months—especially prevention of certain communicable diseases. In addition, recent research suggests that good health in the mother during the period before conception is a possible factor in preventing congenital anomalies.

Cleft palate, harelip, clubfoot, birthmarks, and some other congenital anomalies have many factors in common. They resemble one another not only in being present at birth but also in provoking similar attitudes in the community, the family, and the patient. Besides, the same kinds of social, psychological, educational, and vocational problems accompany them.

Dr. Wishik is Director of the Bureau of Child Health of the City of New York Department of Health. Previously he was Chief of the Program Planning Branch of the Division of Health Services, in the Children's Bureau. Dr. Wishik has also been Director of the Bureau of Maternal and Child Health and the Bureau of Crippled Children in Hawaii's Territorial Board of Health.

Dr. Wishik gave this paper at the seventh annual meeting of the American Association for Cleft Palate Rehabilitation, held at Columbus, Ohio.



This is fun, but it is also part of the treatment for these school children with cleft palate.

These problems have profound and varied effects on the relation between the individual and the rest of the community, and thereby place responsibility upon the public to aid in their solution.

Although this paper is concerned specifically with congenital anomalies, it applies also, in varying degrees, to certain other conditions, usually acquired during early childhood, such as strabismus or squint. These resemble congenital anomalies in their effects upon the child's educational opportunities and vocational accomplishment. All these conditions have similar psychologic and social effects on children, and require similar community efforts to meet their needs, and especially to help them to be accepted by other people.

Child needs to experience success

If such a child is accepted by people he is likely to become better adjusted. Nevertheless he will have many troubles if he is not given the help he needs toward getting special schooling, speech instruction, and assistance in vocational planning. It is well known that maladjustment comes not only from one's own feelings and the attitude of others, but from lack of success in meeting the daily problems of life.

In school the child with cleft palate faces greater obstacles than other children do. He may have to stay away from school again and again for surgical treatment. Some children develop ear infections and as a result have difficulty in hearing.

By far the greatest difficulty these children face in school is not being able to talk clearly. And the chances are that the child will not find in his school any opportunity for the special lessons he needs. Speech instruction is one of the weakest elements of our educational system. In every school some children have speech defects that require special instruction to help them get an ordinary education, but very few are receiving such instruction. State and local school boards need to exert greater effort so that most of these handicapped children can get an ordinary education, and so that children who need special education can get it.

If a child's cleft palate is not corrected by the time he reaches the age for entering employment, especially if he still has trouble in speaking, he will have less opportunity for jobs than the average youth. With the recent remarkable technical advance in devices for mechanically closing the palate, we hope that job difficulties due to de-

fective speech accompanying cleft palate will decrease.

Until we can eliminate such speech defects entirely, such young people will have limited opportunities for employment, and they will continue to need special vocational help. For each youth so handicapped his parents and everyone else concerned should recognize as early as possible the probability that he will be limited in his opportunities for jobs and should consider this probability in planning his schooling. During his early high-school years, at the latest, vocational plans should be made and appropriate training begun.

The best occupational planning and training, however, will fall short of meeting the problem so long as many employers continue to resist employing handicapped persons. The public employment services can render greatly needed help to this group of handicapped young people, not only by finding suitable job openings, but also by providing counseling service in the light of local vocational opportunities.

Public and private resources are needed

The rehabilitation of persons with cleft palate requires a teamwork approach by different professions and by various types of community agencies. Even the medical aspects of the care of cleft palate cut across a number of medical specialties, and include, among others, treatment of cosmetic factors, of dental defects, of feeding difficulties, of speech disturbances, and of hearing impairment. The battery of medical and allied personnel that is called upon includes the pediatrician, the plastic surgeon, the rhinologist, the otologist, the dentist, the orthodontist, the prosthodontist, the psychologist, the social worker, the hospital nurse and the public-health nurse, the nutritionist, and the public-health administrator. Special education calls upon the speech correctionist, the special teacher for the hard of hearing, the vocational counselor, and the teacher giving vocational training. Community resources called

into play include private doctors and dentists, hospital clinics, the public-health department, the school system, and agencies for vocational rehabilitation and placement.

A cleft-palate team might conceivably be set up in a clinic by a voluntary agency. To employ the full complement of professional personnel required is so expensive, however, that some type of direct or indirect support from public funds is almost invariably necessary. If the many community resources contributing to the cleft-palate team are to cooperate effectively, the interested public agencies must participate fully. In addition, to keep the team operating smoothly, one of these public agencies should coordinate the official and voluntary resources into an integrated community program.

Team training for workers

It is not sufficient to establish and support a setting for professional and community teamwork for correcting congenital anomalies such as cleft palate. It is also important that professional workers *train* together so that it will be easier for them to become part of the team. By such team training each professional worker would learn the role

he plays, together with members of other professions, in a well-rounded rehabilitation program for children with these anomalies.

Establishing and maintaining training centers for workers to deal with specific conditions such as cleft palate, cerebral palsy, or rheumatic fever is expensive and can be borne by few university centers. It therefore becomes a public responsibility to recognize and to meet the great lack of personnel trained and qualified to give care for such special conditions and handicaps. Public funds are needed to support the development and maintenance of a number of training centers in different parts of the country. Additional funds should be forthcoming for scholarships and fellowships to enable people with adequate basic professional background to prepare themselves by postgraduate study to contribute to rehabilitation programs.

To obtain reliable statistics on the incidence of cleft palate, some type of *central registration* should be established in each large city, and in each State, for areas not otherwise covered. From such data studies can be made from which possible correlations with causative factors might be derived. In addition, more accurate information on

the number of persons affected in different areas and in different age groups would be valuable in establishing community policy and in stimulating interest in expanding available services. Central registers should be limited to major identifying information, to compilations of numbers of persons, and to data needed for special studies.

For continuity of service to the child

The effectiveness of the central registration register depends upon the completeness of reporting by private practitioners and by agencies giving care to children with cleft palate. A report should be made soon after the child is born. Many communities have an item on the birth certificate concerning congenital defects. And physicians and hospitals responsible for filling in birth certificates should furnish this information conscientiously. In addition, in some communities special reports on certain types of defects are made to the health department.

The child with cleft palate needs rehabilitation services for a long time—at least throughout the growing years of his life. Almost at the beginning we can establish a rather accurate timetable on the care the child will need as he grows. This timetable may include lip closure in the first weeks of life; consideration of the advisability of surgical closure of the palate during the preschool years; pediatric and medical social service, and special dental care throughout childhood; speech instruction before entering school if possible, and certainly in the lower school grades; use of prosthetic appliances during the school years; orthodontic work in adolescence; and counseling, social services, and vocational planning and training during the adolescent years.

Too often, despite the possibility of setting a timetable for meeting needs, the child is lost sight of and care is discontinued. It should not be that professional services are rendered only in response to the family's seeking such services, for there is no common-sense method

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A speech therapist is using a mirror to help this youngster to learn to speak normally.



FOR THE CHILD WITH NO FAMILY OF HIS OWN

ALMEDA R. JOLOWICZ

"THIS BABY has nobody of his own that he can count on. He has only the county welfare department, and we must find some kind of home for him that can become his own." That is what we of the department staff say to ourselves when a child under our care seems at first to be "unadoptable." In spite of the adverse opinion of others about a baby, we strive to place him in a permanent home through adoption, for we believe that every child belongs in a family of his own.

One of these "unadoptable" babies is Charles, the child of an unmarried mother, who was born by a breech delivery, with clubfeet. After his feet were placed in casts, he developed feeding difficulties. And during the next 2 weeks his spasms, crying, and spastic movements led the hospital doctors to believe that he had cerebral palsy. Later they changed this diagnosis, on the ground that before birth he may have had a cerebral hemorrhage that had since been absorbed. They thought that regardless of this possibility the baby might not be entirely normal.

At this point a social agency referred Charles to our department of welfare as "unadoptable." We placed him in a boarding home; there he has developed into a good-natured, contented baby, thought by his foster parents to be quite smart. The doctor has had him fitted with braces and orthopedic shoes, and he is expected to need orthopedic care for about 2 years.

His foster mother thinks she noticed a spasm lately, but we think she may be mistaken, for we know that the baby's grandmother told her about the physical difficulties



If a mother decides to give up her baby, he may have no one of his own to count on.

he had had during his first weeks of life. We plan to have Charles tested by a psychologist and reexamined by a neurologist. Knowing already that the baby's mother is an emotionally immature, self-centered girl who sees no connection between her own life and her child's destiny, we know that Charles can count only on us. We want very much to find some family

who will adopt him for their own.

Our agency, the Nassau County (N. Y.) Department of Public Welfare believes that an agency charged by law with the care of destitute, neglected, and delinquent children, children physically and mentally handicapped, and children born out of wedlock must administer a complete program of services for these children, if it is to serve them responsibly.

Acting upon this conviction, our department administers an adoption program as one of its services to the children of unmarried mothers and to other children whenever placement in an adoptive home is thought to represent the soundest planning for them.

The number of children for whom we find adoption to be the soundest plan is relatively small, in compari-

Almeda R. Jolowicz received her master's degree from Western Reserve University's School of Applied Social Sciences. Now, as supervisor of in-service training in the Nassau County (N. Y.) Department of Public Welfare, she is responsible for the "training on the job" of the agency's child-care and public-assistance workers.

Mrs. Jolowicz gave this paper at the seventy-seventh annual meeting of the National Conference of Social Work, at Atlantic City, N. J.

son with the total number in our care. But the number for whom we consider placement for adoption and later find unadoptable is still smaller. This latter is indeed fortunate because the problems encountered in providing foster care for unadoptable children are serious.

Skill needed in helping boarding parents

When an agency decides, on the basis of careful planning, that long-time care in a boarding home is the best plan for an unadoptable child, the selection of a home must be made with great care. The boarding parents should be as carefully selected for their suitability to the child as if they were to be the adoptive mother and father. They should really want to keep a child for a long time without the finality of adoption. In spite of this care in selection, however, problems will grow out of this situation. And as the child's stay in a boarding home stretches out through the years, the agency will have to anticipate these problems and try to avoid them. If difficulties cannot be avoided through anticipation, they may be at least kept from becoming so serious that they jeopardize the child's stability. The workers will have to use all their skills in helping boarding parents to realize that the staff will continue to share with them the responsibility for the child's well-being in more ways than by issuing a check each month.

The staff should appreciate the fact that long-time boarding care, even in one family home, does not offer full security to a child. This is because he knows that he does not really belong in the foster family. The child will need help in understanding why his name differs from the name of his foster parents and in explaining this difference to other children and to his teachers. The staff should be aware that the child will have questions about why his own people gave him up and why his foster mother and father did not adopt him. The staff must realize that the child may never ask these questions; but the uncertainty they cause, unasked,

may affect adversely his concept of parents and also his attitude toward himself. How staff members of the agency may help a child to ask his questions, and how they may answer them satisfactorily, is something we must give more thought to.

The children we have had to keep in boarding homes because we found them to be unadoptable fall into three groups, which are—

1. Children who were not legally free to be adopted, although their satisfactory development made them eligible for adoption;
2. Children who had major physical defects or who had in their background a combination of questionable factors;
3. Children whose personalities were warped by being left too long in boarding homes without having any close family ties.

I have not mentioned children that might have been considered poor adoption risks because of hereditary factors. But in recent years we have not had a child for possible adoption in whose background we knew there was some disease or condition that has been clearly established as hereditary, such as Huntington's chorea or hemophilia. We have, however, approved for adoption children who had in their background some disorder such as mental illness or epilepsy, the transmission of which by heredity is less clearly established. That the adoptive parents are given full information about such disorders in the child's background goes without saying.

Incidentally, there is one group for whom we have found it difficult to plan either adoption or boarding-home care. These are the Negro children. An extensive drive for boarding homes for all types of children was made last year for several months. A special appeal was made for Negro boarding and adoptive homes. But neither newspaper stories, radio broadcasts, contacts with the members of Negro churches and of other groups having Negro members, nor the formation of a lay committee made up of

white and Negro members have produced any adoptive homes and only one or two boarding homes. Our nearness to New York City and other conditions in Nassau County, and the failure of the department so far to find the right channels into the Negro community are possible explanations of our lack of suitable homes to consider as permanent ones for Negro children, through adoption.

Let us look at the children who are not legally free for adoption. For example, a child is not legally free for adoption if he is born to a married woman whose husband is not the father, unless the husband signs a release for the child's adoption. The cooperation of the husband is required in the adoption proceedings because a child born to a married woman is by law considered to have been born in wedlock. Since the husband does sometimes cooperate, not all children born under these circumstances are unadoptable. He will sometimes sign a surrender of his right to the child or will submit evidence to the court that the child was "begotten and born" during his separation from his wife. Sometimes a mother, however, simply cannot face disclosing to her husband that she has had a child by another man. And she can make no plans to include the child in her life if she hopes to preserve her marriage. For such a child, long-time placement in foster care may be the only possible plan.

Physical defects make adoption difficult

Among the second group, the children who have some major physical defect or some combination of factors in their backgrounds that make their potential development questionable, there are varying degrees of unadoptability. Two children illustrate the kinds of medical problems that would prevent our even considering some children for adoption.

One of these children is a little boy born in a State hospital to a mother whose illness was diagnosed as a psychosis with epilepsy. In infancy the boy was found to be

mentally and physically retarded and to have a condition diagnosed as the petit mal type of epilepsy. The other is a 3-year old girl with a congenital heart condition that has kept her in a hospital for all but 10 months of her life.

Another child, a girl, who was born with one arm but who has developed normally except for this defect, we shall place in an adoptive home if we are able to find one for her. We accept a principle that the Child Welfare League of America has stated about children legally free for adoption, that any child can be placed for adoption if a family can be found who will accept him, with his history and his capacities.

It is readily apparent, however, from the instance of this one-armed girl, that the practical application of this theory presents problems not easily solved.

The resources and skills of a welfare department are also taxed to the fullest in providing a good environment for children so handicapped, who cannot be placed for adoption because their serious physical condition creates recurrent crises in foster homes. Caring for such boys and girls requires so much of a foster mother's energy and time and is such a responsibility that even by paying extra board rates it is difficult for us to find a family that can bear the strain year in and year out. Often when one of these children has to go to a hospital, the foster mother makes his going an occasion for giving him up entirely. When the child is ready to leave the hospital and the foster mother is unwilling to take him back, there may not be enough time for the agency to find "just the right home." Consequently, we must place the child in a home that may not be perfectly suited to this particular child. Then we may have to move him soon. And so, in addition to his initial handicap of physical defect and lack of family ties, the child undergoes the misfortune of being placed in one foster home after another.

We in our agency consider one more group of children unadopt-

able, perhaps the largest group of all. These children have become unadoptable through the mistakes of social agencies, either private or public. Some are children who were not placed early enough because their backgrounds were considered too poor, but who turned out to have potentialities for normal, healthy development. Some are children who were not placed for adoption because their mothers were not helped to make permanent plans for them; others, simply because they were overlooked. Their case records are depressing reading; these reveal the impermanence and instability of a child's life in boarding homes. We in social agencies that carry long-time responsibility for children must face squarely the fact that boarding homes offer very little permanence. Any happening that disturbs family life affects a child who has no legal ties in the home much more poignantly than they affect real members of the family. These disturbances may grow out of such national catastrophes as mass unemployment or war, accompanied by a great moving about of families, or from such family problems as having adult sons and daughters return home because of divorce or widowhood, or from having other relatives move in because of the housing shortage; or from illness or death in the foster family. All leave deep marks on the "boarding" child.

Handicapped child may lose foster home

Even children who have had the advantage of staying in one boarding home grow up with a considerable feeling of insecurity, because they knew all the time they really didn't belong in the families they lived with. Exceedingly destructive to a child's sense of security in such a situation is the fact that he cannot identify himself with the family as he would with his own parents and brothers and sisters. His natural resentment at not having a family of his own and his sense of not belonging to his boarding parents sometimes prevent him from climbing into the lap of the

foster family and feeling secure.

This is one reason, we believe, why some of these children, as they reach the age when foster care for them must end, have no ambitions, no aims, no sense of direction in their lives. Sometimes one of them manages to pick up a little information about one or both parents (often, unfortunately, unhelpful information) and may identify himself with the father or mother. For example, a girl born out of wedlock learned something about her history; later when she became illegitimately pregnant, she said to us: "I'm just like my mother."

The plight of these children, who became unadoptable through the lamentably poor work of social agencies, whose loneliness, whose unhappiness, whose delinquencies, whose inadequacies really represent the failures of social agencies rather than their own, will eventually force these agencies to develop adoption programs adequate in principle and practice to meet the needs of children who, without ties of their own, should be given a chance to make permanent ties with new fathers and mothers. Realizing how much we can help build good lives for these children, the Nassau County Department of Public Welfare today considers for adoption boys and girls who 10 years ago, or 5, or even 2 years ago would have been doomed to spend their childhood in boarding homes.

The factor of unadoptability may greatly complicate work with unmarried mothers and their babies. If the mother has decided that it is clearly best for her and the child that she give him up for adoptive placement, the right plan is to place him for adoption as early as is safe for him. But a complicated problem may arise in connection with the mother's surrender of her right to the child as a step toward placing him for adoption. It grows out of the threefold responsibility of the public agency toward the community as a whole, to the parent, and to the child. The community delegates its responsibility for the care of the unmarried mother and her child to a public agency

that it has created and that it supports and holds accountable. The legal counsel for our department has advised us that in New York State it is the intent of the law that no child shall be deprived of parental support. Thus, no parent, by signing a surrender of his rights before knowing whether his child is adoptable, is released, according to law, from his duty to contribute to the support of the child if later the child is found to be unadoptable.

Application of the viewpoint expressed in the New York law may solve the problem of support of the child but may create others, particularly for an unmarried mother. A release from all reminders of her illegitimate pregnancy and of her child — unadoptable because of some defect — would often serve the interests of an unmarried mother best. Such a release, however, might not serve best the interests of her child, theoretically at least, because it would deprive him of his own family background and heritage for which not even adoption can provide a substitute. Such a release would also make the community responsible for the support of the child. The community, however, is not at present willing to assume this responsibility in full, and therefore requires the mother to pay what she can. On the other hand, the act of not releasing the

parent from responsibility may not insure parental support or family ties that are beneficial to the child, and may seem to punish the mother.

In Nassau County we fully accept the law's point of view that a "surrender" is only an instrument for use in adoption proceedings; and having accepted it, we find that the best interests of the community, of the mother, and of the unadoptable child do not necessarily conflict with one another. The mother who wishes us to place her child for adoption knows from the beginning that we will not accept from her a surrender of her right to the child until our observation of him, substantiated by reports from a pediatrician and a psychologist, shows that he is adoptable.

The mother learns also that if her child is found to be unadoptable we will help her plan otherwise for him and we will explain the responsibility she will be expected to carry. We know that the saying, "You can't get blood from a stone," has a grim sort of reality for social workers, and that nothing can be gained by attempting to force a mother to keep up her natural relation with a child she does not want, especially when she shows her lack of love in a way harmful to him. We appreciate this difficulty fully, and are aware that even though the mother has not sur-

rendered her right to such a child, there may be nothing for him except what our department can offer. Therefore, we deliberate much more carefully before we decide that he is unadoptable. That is why we shall try so hard to find parents for Charles, whose situation we described earlier, in a home to be his own.

The more we broaden our concept of children who are adoptable and the more we find permanent homes for children difficult to place, the more we help both mother and child.

Mother will need help

If, after we have expended all consideration and effort, we find that a child cannot be placed in an adoptive home, we believe we must help the mother to bear this harsh reality. Certainly, no one worthy of being called a caseworker would use the fact that a child is unadoptable in order to punish a mother. Though our interpretation of the law does not permit the department to release a mother from her responsibility to support her child, yet, as the years pass, if the turn of events in her life makes it impossible for her to continue to play a part, financially or otherwise, in the life of her child, the department will assume responsibility for him. We will place him in group or family foster care, whichever is best for him, and will do our part in caring for him as long as our responsibility lasts.

This seeking to widen the sphere of adoptability for the children whose course we are expected to chart, we consider at present one of the dominant activities of our program for unmarried mothers and their babies. Our concentrated efforts began as recently as 1948, although the department has always placed some children for adoption. During the past 3 years we have been able to bring more focus and more direction to our adoption work by centralizing in one supervisory unit our work with unmarried mothers and with all children for

(Continued on page 152)

Every child needs a family—his own or an adoptive one—to give him security and love.



IN THE NEWS

National defense.—Quick surveys are being made of health and welfare conditions in areas that will be affected by the Atomic Energy Commission's new projects in various parts of the country. Regional offices of the Federal Security Agency, through representatives of the Children's Bureau and of other constituent agencies, are making these surveys with the cooperation of State departments of health and welfare, at the request of the Commission. Staff members are preparing analyses of the conditions found, in the light of the emergency changes expected; these analyses are for administrative use only.

Typical of the new projects is the Savannah River Project. This is located on the South Carolina side of the river, about 30 miles below Augusta, Ga. The surrounding area, where the workers and their families will live, is expected to include 12 counties—7 in South Carolina and 5 in Georgia.

The plant itself is to be designed, constructed, and operated by private industry, for the Commission. It will be built on a site covering 200,000 acres, and all the families living on that land will have to move, as no residences are to be located on the project site. Estimates are that 1,500 families will have to find new places to live.

The emergency problems of these families, and of thousands of other families that will be moving into the area around the project site, will undoubtedly require a great increase in maternal and child-health and social-welfare services. For the survey makes it clear that the services available to the people now living in the area will not be adequate to meet the needs of the thousands of families who will be coming in. And as the population grows and congestion increases, many families will need help in adjusting to life in a new place, where housing, school facilities, and recreational opportunities will probably be inadequate, as well as health and social services for mothers and children.

Additional maternal and child-health centers will be needed, in locations where people can get to them easily. And with children

coming into the project area from all over the United States, those of school age will especially need services, among them immunizations and dental services. Plans for meeting the health needs of mothers and children should not only provide the usual health services for them, but should take into consideration their social and emotional needs.

Only limited day-care facilities were found in the area. If mothers of young children take jobs, day-care services will have to be provided.

Teen-age problems are likely to be increased in new communities, and ways to meet these will be needed.

During the construction period for such a large project, with a concentration of single men, the illegitimacy rate is likely to rise in the surrounding communities, where conditions will be unstable and community services lacking. Some girls and young women will need help in planning, not only for their babies, but for their own future lives; many of them will not be able to pay for care during pregnancy.

Other social problems will be intensified and will become more widespread on account of the unsettled conditions that such a great outgo and influx of people is likely

to bring, and social services to meet these problems will be needed.

A similar quick survey has been made in the area affected by the Paducah (Ky.) atomic project. This area includes eight counties in southwestern Kentucky and three in southern Illinois.

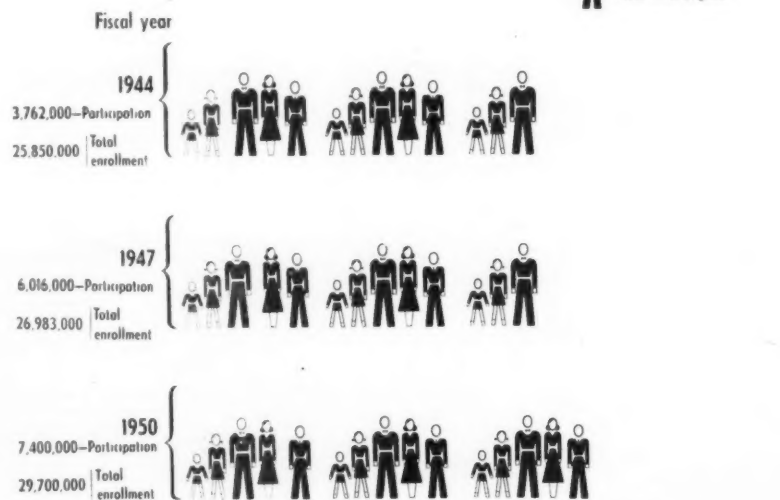
UNICEF.—A traveling dental office and a mobile X-ray laboratory, designed to take health services to the children of rural Uruguay, have been shipped by United Nations International Children's Emergency Fund (UNICEF) for use in that country's maternal and child-health program.

Number of births.—More babies were born in the United States in the 5 years since the end of World War II (1946-50) than in any previous 5-year period in our history. The 5-year total came to 18½ million.

Registered births in 1950 are estimated by the National Office of Vital Statistics, Public Health Service, to be 3,548,000, compared with the final figure of 3,559,529 for 1949. The record high, in 1947, was 3,699,940 registered births. If unregistered births were counted in, NOVS believes 1950 births would total 3,699,000.

Birth rates based on registered births per 1,000 population were 24.4 (provisional) in 1950, 24.9 in 1949, 25.3 in 1948, and 27.0 in 1947.

The National School Lunch Program is another way to raise children's level of living



4-H Club idea.—Rural youth clubs have spread rapidly in Latin America during the past year, according to the U. S. Department of State. The clubs are patterned after 4-H clubs in the United States. In the countries south of us, the Institute of Inter-American Affairs is helping to get them started and growing. A recent survey shows 413 such clubs, with 8,300 members, in seven Central and South American countries.

Like the 4-H Clubs sponsored by the U. S. Department of Agriculture, the Latin-American clubs have projects that vary according to the social and agricultural needs of the community.

General guidance, especially on technical projects, is given through the "Servicios Cooperativos," the device developed by the Institute to obtain close international cooperation in technical matters among the American Republics.

"ADC."—Families receiving aid to dependent children, under the Social Security Act, continued to increase in number during the first half of 1950, but the number tended to level off in the last half. The number of families aided in December, about 640,000, though 40,000 above the number in December 1949, was nearly 15,000 smaller than the number in June 1950. Thirty-two States shared in the June-December decrease and 14 States had decreases from the previous December.

Opportunity for employment was

generally better in 1950 than in 1949. The amendments to the old-age and survivors insurance title of the act that became effective in September 1950 raised the benefits of some families who previously had needed aid to dependent children to supplement the insurance benefits; other ADC families became eligible for benefits under the amendments. The resumption of United Mine Workers' Health and Welfare benefits took some additional families off the ADC rolls. In a few States, reductions in the number of families receiving ADC payments resulted from administrative cuts to keep expenditures within appropriations. These cuts were made because the appropriations had not kept pace with increases in the number of families needing this aid to dependent children and in the cost of living. Some other States reduced payments instead of the number of families receiving aid.

The 1950 amendments to the ADC title of the act relieved the finances of most State public welfare agencies to some extent; through these amendments, Federal funds can now be used to pay part of an amount included for the mother or another adult relative who cares for the children, if that relative is taken into account in determining the amount of the payment. In some instances, also, Federal funds were part of the assistance given to fathers incapacitated for work. This was under the new category of "aid to the permanently

and totally disabled." The new Federal funds made it possible for some States to restore or reduce earlier cuts in payments or to increase allowances for food or other requirements to bring them more nearly in line with current prices.

Average payment for all States was \$74.17 in December 1949, \$70.37 in June 1950, and \$70.61 in December 1950. The number of children aided per family averaged slightly more than 2.5.

Infant mortality.—The lowest infant mortality rate ever recorded in the United States occurred in 1950, when the estimated rate was 29.2, Public Health Service's National Office of Vital Statistics reports. This represents a drop of 6 percent from the rate of 31.1 for 1949, and of 38 percent from the 1940 rate, which was 47.0.

Rates are based on the number of deaths under 1 year per 1,000 live births. Actual number of infant deaths in 1950 is estimated as 103,700.

FSA represented.—Many decisions of the Office of Defense Mobilization will affect children in some way, through their families or through public services. The Office's Manpower Policy Committee, brought into being by defense mobilization order No. 5, is directed by this order to add to its membership, when housing and community services are being considered, the Housing and Home Finance Administrator and the Federal Security Administrator, under whom the Children's Bureau functions.

Shortage of nurses.—Ten percent of all girl high-school graduates in this country will have to be recruited as student nurses to obtain the minimum of nursing manpower proposed by the American Nurses' Association for 1960, according to Ruth Freeman, R. N., nursing consultant with the National Security Resources Board and associate professor of public-health administration at Johns Hopkins University.

The National Security Resources Board's Health Resources Advisory Committee is studying the need for nurses and will soon be able to state definitely the minimum number needed. Meanwhile, the American Nurses' Association has estimated, Miss Freeman says, an immediate need for at least 63,000 more nurses than are now active.

Miss Freeman points out that it would take several years to catch

The post-war "wave" of births requires rapid changes in services and facilities

Adjustments must first be made for toddlers, then school-age children, and finally adolescents



up with the existing deficiency in nurses "even if we get the most we have any right to expect."

School lunches.—More than 8½ million boys and girls—a new record—took part in the National School Lunch Program in November 1950. This tops the previous record number, reached in 1949, by 10.5 percent.

Over a billion and a quarter meals were served to these children in elementary and high schools during the 1949-50 school year, 64 percent of the meals being what is known as the type-A lunch. That is a complete meal, containing one-third of the body's nutritive requirements for a day.

School-lunch officials in the Department of Agriculture, which administers Federal grants for this program, estimate from present trends that 1950-51 figures will show an increase of 164,000,000 meals served, and that 67 percent will be type-A lunches.

Despite the notable strides reported, this program, in operation in all the States and Territories, still reaches less than a third of the nearly 30,000,000 pupils in elementary and high schools.

WHO nurses.—Twenty nurses from Switzerland, South Africa, Denmark, Great Britain, Eire, United States of America, Canada, and Holland are now working in scattered outposts of the United Nations World Health Organization (WHO).

Wearing no special uniforms, they frequently live under primitive conditions with WHO field teams and missions in jungles and stricken villages. Their duties take them to such widely differing countries as Borneo, Greece, China, Egypt, South Korea, Pakistan, Ethiopia, India, Haiti, Thailand, and Malaya.

Mortality statistics.—An invaluable tool in planning programs for lowering mortality of prematurely born and newborn babies, statistics on these deaths are getting special attention these days. Much of the usefulness of these figures to health and medical workers depends on the comparability of the data. Recommendations for better data-gathering have been released by the Public Health Conference on Records and Statistics, the Association of Maternal and Child Health and Crippled Children Directors, the Children's Bureau, and the National Office of Vital Statistics. Copies

of their joint statement, which is of interest to public-health workers as well as to statisticians, may be obtained from the Children's Bureau or the National Office of Vital Statistics, Federal Security Agency, Washington 25, D. C.

From the census.—Census figures for 1950, based on a preliminary sample, show that 53,932,000, or 35.8 percent of our 150,697,000 population, are under 21 years of age. Of these young people, 12.1 percent are of races other than white. For the first time in any decennial census, more children were living in urban than in rural areas. The proportion in urban areas is 57.8 percent; in rural non-farm areas, 22.9 percent; and on farms, 19.2 percent.

Child labor.—Over a million children 10 to 13 years of age—one out of eight youngsters of these ages—had jobs in August 1950. Even in October, a school month, 719,000 were working, or 1 out of 12.

This new count of child workers, made by the Census Bureau for the U. S. Department of Labor's Bureau of Labor Standards, includes children working in agriculture, and in stores, as newspaper carriers and sellers, baby sitters, and domestic workers.

Half these youngsters worked without pay, and many thousands of them for 35 hours or more per week.

Nearly two-thirds, 629,000, of the children with jobs were working in agriculture in August. In October, that number had dropped to only slightly less than a half million, 447,000. Of the 188,000 who worked for pay in August, 74,000 put in 35 hours or more per week. Unpaid agricultural workers 10 through 13 years old totaled 441,000 in that month, and 156,000 of these worked 35 hours a week or longer. Characteristically, these children worked on their parents' farms. Except for a small number of children classed as self-employed, no child was counted as working in agriculture unless he put in at least 15 hours in a week.

Farm clubs, India.—Two young people's farm clubs have been organized in New Delhi, India, under the sponsorship of the new "young farmers' movement." These are expected to be the nucleus of a national farm organization, much like 4-H clubs in the United States, to promote and develop an interest in rural problems.

GROUP WORK

(Continued from page 140)

their joining together. When the members of a group like each other, they create a climate that encourages the individuals to support and encourage one another.

The Y-Actives were such a group. The worker was aware of the good relations between the various members and strengthened these bonds through her own friendly, easy contacts with them, by helping each member take an active part in the meetings and encouraging the group to keep focused on its common interests and needs. She worked to give these young women the backing they needed to face their real feelings and desires. And with her encouragement they found that talking with one another frankly about the ups and downs of home life—of marriage, pregnancy, and child rearing—and filling the gaps in their information about these subjects lessened their anxieties and strengthened their confidence in themselves as wives and mothers. The social group worker's role, in general, was to create for the members the atmosphere of mutual appreciation.

Although the group worker never lost sight of the fact that it was the contact of one member with another during these regular associations that brought about results, she did use individual interviews as a supplementary tool in helping the members to achieve more satisfying family life. Opportunities came when she had to talk to the officers and other members about the duties they had accepted for the group. Unobtrusively she made opportunities to talk briefly with individuals in such a way as to encourage them to work out some of their difficulties. She interviewed such members as Mrs. O and Mrs. H by appointment in an effort to enable them to understand more clearly what was preventing harmony at home. She helped them to realize that they needed outside help to get things at home on an

even keel, and she encouraged them to go to the specialized agency that could give them guidance. She kept in touch with their experiences with these agencies. This service required, of course, not only an understanding of individual needs, but interviewing skill and a knowledge of the other resources in the community.

Members learn from one another

In evaluating the group experience toward the end of the year, the "Y-Actives" said freely that the club had meant a great deal to them; that it had served as a retreat from the duties and difficulties of their home life and at the same time had helped them to handle these duties and difficulties more effectively. The club was a place where they could get sympathy and understanding from one another and from the worker. They had learned to do new things that interested them; they had drawn their husbands into the social part of their program, which helped to give the couples a social interest in common. It meant a lot to them to learn that other parents have troubles too and that a certain amount of stress and strain was normal and to be expected.

The agency, in reviewing its work with the group, concluded that it had fulfilled its purpose, to help members to find personal satisfactions through recreation and other programs in line with their interests and to help them meet their common problems and needs so that they might be able to participate more effectively in family and community life.

Thus, social group workers can use their skills—based on an understanding of how human beings behave and why, on the dynamics of group life, and on knowing about other services in the community that may be called on for cooperation—to assist young married couples in such a way that the quality of their family life brings satisfaction to themselves and provides a home atmosphere in which their children may develop healthy personalities.

Reprints in about 6 weeks

CLEFT PALATE

(Continued from page 143)

whereby a family will know at what age in the child's life each type of service should be given. Therefore careful and continuous follow-up measures with **local service registers** should be established through a local coordinating agency, such as the crippled children's services of a health department, so as to give the child continued care through the combined efforts of all the public, voluntary, and private community resources available. Because of the complex nature of the problem and the need for community coordination, the public agencies operating or supporting a cleft-palate program should make full use of competent technical and community advisory committees.

Because treatment takes so many years, and because the procedures, surgical and nonsurgical, usually have to be repeated again and again, the cost of correcting a child's cleft palate is prohibitive for most families. The burden of care therefore falls to a large degree upon public and voluntary agencies. And the complex battery of services required is as a rule too costly for voluntary agencies. Therefore, public funds are necessary for supporting community services for the restoration of children with cleft palate.

A public agency that carries on or supports a cleft-palate program should have adequate standards of service. Standards should be established for facilities and services in clinics and hospitals and for qualifications of personnel. A broad approach to the social and educational needs of the child is also an integral part of an effective program. If a public agency is to reach high standards in its cleft-palate program, it must pay high enough fees to professional persons and to hospitals and other voluntary agencies to obtain the desired high quality of service.

The community that does not give good service to its children with cleft palate is wasting dollars. Services that are rendered early

and are well timed to the needs of the growing child prevent the development of conditions which would, if untreated, require still more services. For example, the child whose cleft palate has been improperly closed needs more speech instruction during his school years than if his defect had been properly corrected. Again, the child with improper or inadequate lip surgery or palate treatment needs more orthodontic treatment during adolescence. Whenever any step in service is rendered later than it should have been, more service is required. And not only is more service needed, but the results of rehabilitation are of course less complete. The patient's potential contribution to society is sharply curtailed, and the possibility of his becoming a drain upon the community in later years is increased. Inadequate care, in the end, costs the community much more than good care.

To summarize

We have listed and described the many ways in which the public, through Federal, State, and local agencies, is called upon to meet the rehabilitation needs of children born with cleft palate. The problem is not one for public agencies alone, but one for public agencies along with voluntary agencies and with individuals all joined in a community effort. The local health department has a great responsibility for coordinating community efforts to obtain for children with cleft palate complete rehabilitation and continued care, according to a rather well-established timetable. In a cooperative community program, specialized efforts for the child with cleft palate, in the form of establishment of a special clinic, with team training, should be balanced by strengthening general community resources—speech instruction in the schools, vocational training, job placement, and public education. Strengthening these services will benefit not only the children with cleft palate but also many other children.

Reprints in about 6 weeks

ADOPTION

(Continued from page 147)

whom adoption may be considered. Thus we are developing our adoption program more in proportion to the department's great responsibility to children.

No matter how well the adoption program of a public agency develops, no matter how liberal and flexible the department's decisions become on what children are adoptable, and no matter how resourceful the department grows to be in finding homes for children who might once have been considered unadoptable, the number of children placed for adoption will be small in proportion to the total number of children being cared for. Nassau County had, as of March 31, 1950, 1,072 children under care. Of this number, 727 were in boarding homes, 100 were in group care, and 37 were in adoptive homes. Though we hope that with the further maturing of our adoption program we shall have more children in adoptive homes under supervision a year from now, the disproportion between the number in this group and the number in other kinds of foster care will probably continue.

This is as it should be, we believe, in view of the basic principle of child-welfare work, that no child shall be deprived of his own family unnecessarily. The great majority of children who are in boarding homes and institutions are still bound to their parents by both emotional and legal ties. While we would acknowledge that many children have been "lost" in the care of public agencies—those children we have spoken of for whom agencies failed to consider adoption until too late—we would also insist that an agency can serve children best by helping their parents to carry the responsibility of parenthood to the fullest degree of which they are capable. This is certainly the opposite of placing children for adoption.

Reprints in about 6 weeks

To remind you—

Each year, according to law, the Federal Security Agency sends each person on the official mailing list for **The Child** a postal card asking whether he wishes to continue to receive it.

When you receive such a card, be sure to answer it, if you want your name to be kept on the list.

• FOR YOUR BOOKSHELF

THE NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE PRESENTS CHIC YOUNG'S "BLONDIE." Albany, N. Y. 1950. 16 pp. Available to recognized agencies and organizations interested in the promotion of mental health.

To the New York State Department of Mental Hygiene, a big bouquet for letting a beloved comic-strip family show us how it handles some of its mental-health problems. Flowers to the producer of this new type of comic book, too, who shows such real understanding of the booby traps that lie in wait to snare unwary family members.

Loud and continuous have been the laments going up over the scarcity of materials through which ideas, as well as information, can catch the attention of those who do their reading on the run, or in the subway.

How to reach people who can't be induced to plow through lengthy treatises on how to make their marriages and their children happy has wrinkled many a brow. This new approach the New York State Department of Mental Hygiene is using is anything but solemn, and it is all the sounder for it. And in the episodes in which Blondie and Dagwood and their children tangle with human relationships, every reader will recognize himself a lot quicker than he would in textbook case histories, and will have his risibilities stirred, instead of feelings of guilt.

"In utilizing this sprightly medium," says Commissioner Newton Bigelow, "we hope to reach the

same public that is reached by comics in general—cutting across all social and economic strata and embracing every age level." We hope there will be such a wide demand for this effective, sharp-attacks educational device that many others as delightful will follow.

Marion L. Faegre

THE CHILD WITH CEREBRAL PALSY. Federal Security Agency, Social Security Administration, Children's Bureau Folder No. 34, Washington. 1950. 13 pp. Single copies free.

The outlook for the Nation's 175,000 children with cerebral palsy is brighter today than ever before. Not long ago cerebral palsy was looked on as hopeless. Now help is being brought to more and more of these youngsters, says this new booklet.

A growing number of communities throughout the country have public-health clinics and special facilities that provide the care needed by cerebral-palsied children. Schools are providing increasingly for these children through special services. And parents of cerebral-palsied children and children with other crippling conditions are working together to get the needed services for their children.

Prepared especially for parents of children with cerebral palsy, the booklet says the disease is caused by damage to the brain—either before birth, at birth, or after birth—and brings about poor coordination of the muscles of the face, the throat, the arms, the legs, or other parts of the body.

Children with cerebral palsy, the booklet emphasizes, are not necessarily feeble-minded, as some think. Although some are mentally deficient as a result of cerebral palsy, some are very bright. If these children are in a good program of care and have opportunity for suitable education, many of them develop intellectually as other children do.

Cerebral palsy is not inherited, nor is it contagious, the booklet says.

Like all children, cerebral-palsied children learn a great deal from being with other children. So parents of children with this condition should not isolate and overprotect them, the booklet cautions, but should encourage them to play with other children, to attend school,

and to do as much for themselves as they can.

A limited supply of "The Child With Cerebral Palsy" is available without charge from the Children's Bureau. Copies may also be purchased at 10 cents each from the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

ADOPTION LAWS IN LATIN AMERICA. By Anna Kalet Smith, Federal Security Agency, Children's Bureau, Publication No. 335, 1950, Washington. 34 pp. 15 cents. Superintendent of Documents, Government Printing Office, Washington 25, D. C. Single copies may be had free by writing to the Children's Bureau.

With the growing importance of adoption as a child-welfare problem, the demand has been increasing for information on adoption laws in foreign countries. This bulletin, planned to acquaint the public with the laws of Latin America, contains the history of adoption legislation in Latin America since the Colonial period, an analysis of the present laws, and translations of those now operating in 15 Latin-American countries.

YOU AND YOUR HEART; a clinic for laymen on the heart and circulation. By H. M. Marvin, M. D.; and T. Duckett Jones, M. D.; Irvine H. Page, M.D.; Irving S. Wright, M.D.; and David D. Rutstein, M.D. Random House, New York, 1950. 306 pp. \$3.

Written for the layman, this book includes information about the major types of heart disease, including rheumatic fever and congenital heart disease.

CHILD ANALYSIS NUMBER OF THE PSYCHOANALYTIC QUARTERLY, 1935. Reissued in 1950 by the Psychoanalytic Quarterly, Inc. 57 West Fifty-seventh Street, New York 19, N. Y. \$5.

Fifteen years after it was first published, this collection of papers concerned with the analytic approach to children still stands as an important contribution. The problems in applying analytical knowledge in the education of children

are just as pertinent and important today; and the dilemma of the child analyst in relation to the parental environment of the little patient, discussed by Burlingham, has not yet been resolved in a completely satisfactory way. Several of the clinical studies may be regarded as classics in the field of child analysis. We may be grateful that they are now easily available in this re-issued edition.

The authors included are Anna Freud, Siegfried Bernfeld, Anni Portl, K. Pensimus, Erik Homburger, Dorothy Tiffany Burlingham, Berta Bornstein, Anny Angel, Edith Sterba, Edith Buxbaum, and Steff Bornstein.

Betty Huse, M. D.

INFANT NUTRITION; its physiological basis. By F. W. Clements, M.D. Williams & Wilkins Co., Baltimore, 1949. 246 pp. \$4.50.

Modern knowledge of infant nutrition, gleaned from the literature of many countries, is assembled in this book in orderly and interesting form. Basic data on metabolism, physiology, and the properties of specific foods are given, followed by practical interpretations in terms of nutritional requirements.

A brief chapter is devoted to tissue metabolism, and four are concerned with fetal nutrition. Post-natal nutrition is dealt with under the following headings: The chemical and physical properties of human and cow's milk; Digestion in the young infant; Water metabolism; Energy requirements; Requirements of nutrients; Application of the principles; Disturbances of metabolism of dietetic origin.

The author has shown great skill in thoroughly documenting the material presented without letting this interfere with easy readability. The extensive bibliographies following the chapters indicate the wealth of material on which he has drawn and provide a valuable source of references for those wishing to consult the original literature.

Marian M. Crane, M. D., and Helen Stacey

OUR COOPERATIVE NURSERY SCHOOL. Silver Spring Nursery School, Inc., Silver Spring, Md. Revised edition. 1949. 100 pp. \$1.50.

This second manual of the Silver Spring Nursery School, Inc., which

was organized in 1941, is planned for the information of the members of the cooperative association that administers the nursery school and of the many persons who have visited and written to it — parents wishing to organize similar schools, other persons studying cooperative movements, students, teachers, and administrators interested in the nursery-school field.

The book explains in detail the organization of the cooperative nursery school, the duties of the mothers who participate in the work, and the relation of the school to the community. Finances, publicity, housing problems, business meetings, and annual meetings all come in for consideration. The appendix includes some useful guides, such as by-laws and forms, and rules to be observed when driving children to school and to their homes.

CHILD LABOR FACT BOOK, 1900-1950. By Florence Taylor. National Child Labor Committee, 419 Fourth Avenue, New York 16, N. Y. Publication No. 403. April 1950. 26 pp. 25 cents.

The early 1900's saw a rising interest in the child workers of the United States and an active concern about the conditions under which they were employed. This pamphlet, one of a series of child-labor fact books issued annually by the National Child Labor Committee, reviews that period and tells the changing story of child-labor conditions and social attitudes toward child labor during the past 50 years.

Devoting a section to each 10-year period, the leaflet gives the numbers and ages of working children at the beginning of the period, and facts about child-labor legislation, State and Federal, during that decade. It also traces the changes in public attitudes toward child employment and education. Census figures for young workers are given in a chart, showing differences from decade to decade in the composition of the young-worker force of the country.

The story of Federal action to control child labor is traced, from the first Federal child-labor law, declared unconstitutional in 1918, through the unsuccessful attempts to obtain a child-labor amendment to the Constitution and the child-labor standards of the NRA Codes,

and finally to the child-labor provisions of the Fair Labor Standards Act of 1938 and the strengthening amendments enacted in 1949.

The extent to which individual State laws now accord with certain generally accepted standards is outlined. These standards are: a 16-year age minimum for all employment during school hours; a 14-year age minimum for employment outside of school hours and during summer vacations; maximum working time of 8 hours a day, 40 hours a week, and 6 days a week for boys and girls under 18 years; limitation of hours of part-time employment for boys and girls under 18 years while schools are in session; prohibition of night work for those under 16 years and those under 18 years; requirement of work permits for those under 18 years; prohibition of hazardous occupations for those under 18 years.

Ella Arvilla Merritt

INTERNATIONAL SURVEY OF SOCIAL SECURITY. International Labour Office, Geneva, 1950. 236 pp. \$1.50.

A social-security system in a given country is a set of legal provisions creating specified benefits for specified groups of persons in specified circumstances. Social security includes, in the first place, compulsory social insurance — aided and regulated by the government — against the contingencies of illness, maternity, prolonged disability regardless of cause, unemployment, old age, or death of the family breadwinner; and, secondly, health services and other kinds of assistance made available by the government independently of social insurance. Voluntary insurance, if subsidized by the government, also is included.

The present survey, giving information on 45 member countries of the International Labour Organization, consists of two parts. The first contains an analysis of the main elements of the laws, such as contingencies for which benefits are provided, persons protected, definition of benefits, and organization and financing of social security. The second part, in which these elements are discussed by countries, includes (1) a table giving for each country the categories of persons protected and the contingencies for which benefits are provided, and (2) text, divided into sections, one for each

of these contingencies; in each section a brief description of the nature of the benefits is given for each country.

Summaries, by countries, on the organization and financing of social security conclude the report.

This manner of presentation is helpful in mastering the intricacies of social security; but the numerous repetitions in the text are, to this reviewer, a hindrance in the process. Another inconvenience is the absence of complete summaries by countries, with dates of laws and references to the published sources, for the benefit of readers who are interested in the total situation in a particular country.

Anna Kalet Smith

**EXPERT GROUP ON PREMATURE-
ITY; final report.** World Health Organization Technical Report Series, No. 27. World Health Organization, Geneva, 1950. 11 pp. 10 cents.

Recommendations concerning babies born prematurely, drawn up by the Expert Group on Prematurity, of the World Health Organization, are presented in this pamphlet.

The group recognizes the necessity for uniform terminology concerning prematurity, for international use in programs for saving the lives of premature babies. And, in spite of the disadvantages in using birth weight as a criterion, the report suggests that a premature baby be defined as one whose birth weight is 2,500 grams (5½ lbs.) or less.

The group believes that consideration should be given to two types of program: (1) A preventive one directed toward lowering the incidence of prematurity; (2) a program for special care of infants prematurely born. The members agree that a country might be able to initiate one of these types of program before a complete program is developed, or it might start one or more local programs before making them country-wide. The requisites for each type of program, and the content, are given; and the development of a complete program is outlined.

The need for training physicians, nurses, and midwives, and for doing research in prematurity, is emphasized in the report. Lastly, the group recommends that WHO develop an information service on prematurity.

The members of the Expert Group are:

Dr. L. Camacho, Obstetrician; Chief, Maternal and Child Health Centre, Public Health Department, Quito, Ecuador.

Dr. V. Mary Crosse, Pediatrician, Birmingham Regional Hospital Board, Birmingham, United Kingdom.

Professeur M. Lelong, Clinique de Puériculture de la Faculté de Médecine de l'Université de Paris, France.

Dr. S. Z. Levine, Professor of Pediatrics and Pediatrician-in-Chief, New York Hospital, Cornell Medical Center, New York City, United States (chairman).

Miss E. Magnussen, Director, Nursing Division, National Health Service, Copenhagen, Denmark.

Dr. A. Ylppö, Professor of Pediatrics, University of Helsinki; Chief, Children's Clinic, Helsinki, Finland (co-chairman).

The adviser and the secretary are, respectively:

Miss D. Batt, Matron, Training Centre for Plunket Nurses, Dunedin, New Zealand.

Dr. Ethel C. Dunham, Consultant, Maternal and Child Health Section, WHO.

Alice D. Chenoweth, M.D.

YOUR CHILD MAKES SENSE; a guidebook for parents. By Edith Buxbaum, Ph.D. International Universities Press, New York, 1949. 204 pp. \$3.25.

An enormous amount of information about the growth and development of children is included in this small book. Simply written and packed with concrete examples, it presents a way of looking at children and makes the point over and over that there is a reason for everything a child does.

To say that this book is "simply written" is not to say that it is simple to read. Dr. Buxbaum's point of view is based on "dynamic," analytically oriented child psychology, which, as Anna Freud says in her foreword, contributes to our understanding of "the inconsistencies, intricacies, and vagaries of childish behavior which had remained inexplicable until then." Many of the analytical concepts are so emotionally charged and novel to a great many lay persons that it is doubtful whether the majority of parents, for whom the book was written, would find it very useful.

On the other hand, some mothers and fathers who are eager to understand the new knowledge about the workings of their children's minds will find this book admirably suited to their needs.

For professional persons working with children *Your Child Makes Sense* should be a helpful and profitable volume.

Betty Huse, M. D.

Reprints Available

A limited number of copies of the following reprints from **The Child** are available for distribution. Single copies may be had without charge until the supply is exhausted.

Encouraging Initiative in Convalescent Children. By Maree Brower.

Fluoride Technique Demonstrated in Radio Program.

For the World's Children. By Ruth Crawford.

Harlan County Plans for Its Boys and Girls. By Amber Arthun Warburton.

Learning to Live Together. By Katherine Glover.

A Look at Our Training Schools. By Richard Clendenen.

Memphis Attacks Its Rheumatic-Fever Problem. By James G. Hughes, M. D.

Norway Improves Laws Protecting Mothers and Children. By Arnfinn Guldvog.

A Proposal for Joint Action Against Congenital Syphilis. By Betty Huse, M. D., and W. H. Aufranc, M. D.

Psychologist Can Help in Planning for Baby's Adoption. By Helen Rome Marsh.

CALENDAR

May 1-7—Correct Posture Week. Sponsored by the National Chiropractic Association.

May 2-3—Society for Pediatric Research. Atlantic City, N. J.

May 2-5—American Pediatric Society. Annual meeting. Atlantic City, N. J.

May 2-8—National Mental Health Week. Information from the National Association for Mental Health, 1790 Broadway, New York 19, N. Y.

May 4-5—American Council on Education. Annual meeting. Washington, D. C.

May 6-10—Boys' Clubs of America. National convention. New York, N. Y.

May 6-12—National Hearing Week. Information from the American Hearing Society, 817 Fourteenth Street, NW., Washington 5, D. C.

May 6-13—National Family Week. Ninth annual observance, by Protestant, Catholic, and Jewish groups. Information from Rev. Richard E. Lentz, 206 South Michigan Avenue, Chicago 4, Ill.

May 7—Fourth World Health Assembly. Geneva, Switzerland.

May 7-11—American Psychiatric Association. Annual meeting. Cincinnati, Ohio.

May 8-9—President's Conference on Industrial Safety. Washington.

May 9-12—United States National Commission for UNESCO. Annual meeting. (Previously meetings were held semiannually.) Washington, D. C.

May 13-18—National Conference of Social Work. Seventy-eighth annual meeting. Atlantic City, N. J.

Some other organizations meeting in association with the National Conference of Social Work:

American Association of Group Workers.

American Association of Medical Social Workers.

American Association of Psychiatric Social Workers.

American Association of Schools of Social Work.

American Association of Social Workers.

Big Brothers of America.

Child Welfare League of America.

Florence Crittenton Homes Association.

Medical Social Consultants in State and Local MCH and CC Programs (May 12-13, 16).

National Association of Training Schools.

National Child Labor Committee.

National Committee on Services to Unmarried Parents.

National Probation and Parole Association.

National Publicity Council for Health and Welfare Services.

May 14-18—General Federation of Women's Clubs. Annual convention. Houston, Tex.

May 14-18—National Tuberculosis Association. Annual meeting. Cincinnati, Ohio.

May 16-20—National Conference on Citizenship. Sixth annual meeting. Washington, D. C.

May 21-23—National Congress of Parents and Teachers. National convention. Miami Beach, Fla.

May 21-23—National Council of Juvenile Court Judges. Wilmington, Del.

May 21-25—International Union Against the Venereal Diseases. Twenty-eighth general assembly. Paris, France.

May 23-26—American Association on Mental Deficiency. Annual convention. New York, N. Y.

Illustrations:

Cover, Philip Bonn for Children's Bureau.

Pp. 139 and 144, George Jones for Public Health Service, Federal Security Agency.

P. 140, Young Women's Christian Association, Pittsburgh, Pa.

Pp. 142 and 143, Hawaii Territorial Board of Health.

P. 147, National Institute of Mental Health, Public Health Service, Federal Security Agency. (From the movie, "Preface to a Life.")

Pp. 148 and 149, Chart Book, Midcentury White House Conference on Children and Youth.

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APRIL 1951

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Published 10 times a year by the Division of Reports, Children's Bureau
Editor, Sarah L. Doran Art Editor, Philip Ronn

FEDERAL SECURITY AGENCY
Oscar R. Ewing, Administrator

SOCIAL SECURITY ADMINISTRATION
Arthur J. Altmeyer, Commissioner

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Publication of THE CHILD, monthly bulletin, has been authorized by the Bureau of the Budget, September 19, 1950, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to libraries and to public employees in fields concerning children; address requests to the Children's Bureau, Federal Security Agency, Washington 25, D. C. For others, the subscription price is \$1 a year; send your remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.; foreign postage, 25 cents additional. Foreign postage must be paid on all subscriptions sent to countries in the Eastern Hemisphere and those sent to Argentina and Brazil. Domestic postage applies to all other subscriptions.

For most of the Midcentury Conference materials—

write to Health Publications Institute, Inc., Raleigh, N. C.

The five publications named below may be purchased as a "package" for \$5. Also, quantity orders of the individual publications, except the proceedings, may be had at reduced prices.

Official White House Conference proceedings.—This book contains the recommendations of the conference; and the complete reports of the plenary sessions, of the 35 work groups, and of the information panels; as well as the major addresses and technical papers. 400 pp. Cloth, \$4. Paper, \$2.

Digest of fact-finding report.—Our readers are familiar with this digest; we published excerpts from it in a previous issue. 200 pp. \$1. (The complete fact-finding report will be published in the fall.)

Conference platform.—This contains the recommendations adopted at the final plenary session; also the "Pledge to Children." 24 pp. 15 cents.

Pledge.—The Pledge to Children is presented on a scroll, of heavy paper, in three colors. 16 by 25 inches. 50 cents. Printed on lighter-weight paper, and smaller (12 by 18¾ inches), 10 cents.

Chart Book.—We have described this book before. Two of its 75 charts are reproduced in this issue; another one was in last month's. \$1.

Two publications — the Report on State and Local Action (61 pp.) and the Report on Youth, National Organizations, and the Federal Government (122 pp.) — can be bought at 75 cents each from the White House Conference, Federal Security Agency, Washington 25, D. C.

The recordings of White House Conference Highlights, previously mentioned in *The Child*, can also be bought from the White House Conference. Each album, containing seven 16-inch double-faced records, \$10.

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